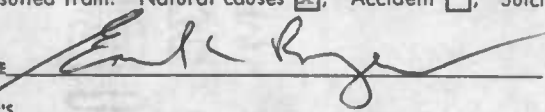
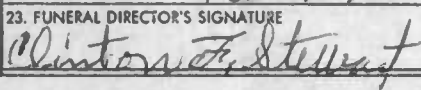
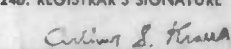


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS 601 B Rose St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roxie Middle Rose Last Lee Alford			4. DATE OF DEATH Month 3 Day 16 Year 60		
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 15 1930			9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Cleo Mumford			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 263-44-2149			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE 			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Earl L. Royer, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 3-21-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/26/1960		22c. NAME OF CEMETERY OR CREMATORY Lake Wales	
22d. LOCATION (City, town, or county) Lake Wales		(State) Florida		24a. REC'D BY REGISTRAR DATE MAR 23 '60	
23. FUNERAL DIRECTOR'S SIGNATURE 			24b. REGISTRAR'S SIGNATURE 		

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3972 CERTIFICATE OF DEATH

03911

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salsibury</u>		LENGTH OF STAY (in this place) <u>since 4/15/59</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u>		<u>05X2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u>				STREET ADDRESS (If rural give location) <u>306 Franklin St.</u>			
3. NAME OF DECEASED (Type or Print) <u>ARTHUR PUE ATKINSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>November 8, 1892</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert J. Atkinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Maddox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-03-9003</u>		17. INFORMANT & ADDRESS <u>Records of Pine Bluff State Hospital</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>590X Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Acute Nephritis</u>				<u>2 wks</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>002X Pulmonary tuberculosis</u>				<u>20 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/15</u>, 19<u>59</u>, to <u>3/15</u>, 19<u>60</u>, that I last saw the deceased alive on <u>3/15</u>, 19<u>60</u>, and that death occurred at <u>8:58p</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward P. Ritchie</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>M.D. Pine Bluff Hospital, Salisbury, Md. 3/15/60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-18-1960</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>MAR 21 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co</u>		ADDRESS <u>Salisbury, Md</u>	

03912

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 Mons.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Rr. Sanitarium				d. STREET ADDRESS Rockawalkin		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Robert		Middle James		Last Atkinson	
4. DATE OF DEATH		Month 3		Day 26		Year 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17, 1869	
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie Atkinson				14. MOTHER'S MAIDEN NAME Jennie Trehearn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Howard Humphreys, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15 , 19 59 , to 4/26 , 19 60 , that I last saw the deceased alive on 4/26/60 , 19 60 , and that death occurred at 12:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 3-28-60							
ACTUAL SIGNATURE Fred R. Gramse M.D. Salisbury, Maryland							
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse S. Division St., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-29-1960		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)
15M 9/59

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3974
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
03915
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 323 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Dennis 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital			d. STREET ADDRESS 1728 River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Francis Middle Atkisson Last Atkisson			4. DATE OF DEATH Month March Day 9 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1946		9. AGE (In years last birthday) 14 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Andrew C. Atkisson			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No			14. MOTHER'S MAIDEN NAME Lillian Berard		
16. SOCIAL SECURITY NO. none			17. INFORMANT Deer's Head Hospital Records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Muscular dystrophy DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 1 day ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Deer's Head Hospital; Salisbury, Maryland	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 21, 1959 to March 9, 1960 , that (I) (we) lost saw the deceased alive on March 9, 1960 , and that death occurred at 9:10p from the causes and on the date stated above.					
22a. SIGNATURE R. J. Gore			22b. DATE SIGNED 3/10/60		
22c. PHYSICIAN'S NAME (Type) R. J. Gore, M. D.			22d. ADDRESS Deer's Head Hospital; Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/12/60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Maryland	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue			
25a. REC'D BY REGISTRAR DATE MAR 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1944

Attest

W. J. Davis

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3975
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03914

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>26 hrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Deers Head Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>M.</i> Last <i>Baker</i>		4. DATE OF DEATH Month <i>March</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-1-1892</i>
9. AGE (In years last birthday) <i>67 1/2</i>		IF UNDER 1 YEAR Months <i>6</i> Days <i>11</i>	IF UNDER 24 HRS. Hours <i>11</i> Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Delaware</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Elisha Nicholson</i>	
14. MOTHER'S MAIDEN NAME <i>Catherine M. Carnean</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>M. Cumming</i> Address <i>104 Pennell St. Snow Hill Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> 722.0 DUE TO <i>Rheumatoid Arthritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>722.0</i> (c) <i>35 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Secondary Cancer</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-10-1960</i> to <i>3-11-1960</i> , that (I) (we) last saw the deceased alive on <i>3-11-60</i> 19, and that death occurred at <i>430</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Lee L. Lawry</i>		22b. DATE SIGNED <i>3-11-60</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Salisbury, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried March 14/60</i>		23b. DATE THEREOF <i>March 14/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Whitson Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Snow Hill Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraw</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 14 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>			

STATE OF NEW YORK

1900

[Faint, illegible text, likely bleed-through from the reverse side of the page]

3976

CERTIFICATE OF DEATH

03915

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>8 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Oliver</u> Last <u>Barry</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1865</u>
9. AGE (In years lost birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland Somerset County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Mr. Robert Barry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Somers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>Hospital Records -- Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage due to generalized arteriosclerosis (9 mos.)</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>59</u> , to <u>3/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/1</u> , 19 <u>60</u> , and that death occurred at <u>3:35P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lee L. Lawry</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>3-2-60</u>	
PHYSICIAN'S NAME (Type) <u>Lee Lawry, M.D.</u>		<u>Deer's Head State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-14-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Miles Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Farmington, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Whitson</u> ADDRESS <u>Princess Anne, Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u> DATE <u>MAR 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3978

DECEASED: [Name] [Address] [City] [State] [Country]

1 *B*
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 3977
 CERTIFICATE OF DEATH

03916

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1267 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 3028 Grantley Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Isaac Middle G. Last Bell (Jr.)				4. DATE OF DEATH Month 3 Day 31 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-08	
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months 3 Days 31 Hours 31 Min. 1960		IF UNDER 24 HRS. Months 3 Days 31 Hours 31 Min. 1960			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber				10b. KIND OF BUSINESS OR INDUSTRY Norfolk, Va.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Isaac G. Bell, Sr.				14. MOTHER'S MAIDEN NAME Margaret May Hansford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. Deer's Head Records			
17. INFORMANT Mrs. Frances Caset (Sister)				Address 3610 Hickory Ave Baltimore 11, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis - acute right posterior DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z) DUE TO (aa) DUE TO (ab) DUE TO (ac) DUE TO (ad) DUE TO (ae) DUE TO (af) DUE TO (ag) DUE TO (ah) DUE TO (ai) DUE TO (aj) DUE TO (ak) DUE TO (al) DUE TO (am) DUE TO (an) DUE TO (ao) DUE TO (ap) DUE TO (aq) DUE TO (ar) DUE TO (as) DUE TO (at) DUE TO (au) DUE TO (av) DUE TO (aw) DUE TO (ax) DUE TO (ay) DUE TO (az) DUE TO (ba) DUE TO (bb) DUE TO (bc) DUE TO (bd) DUE TO (be) DUE TO (bf) DUE TO (bg) DUE TO (bh) DUE TO (bi) DUE TO (bj) DUE TO (bk) DUE TO (bl) DUE TO (bm) DUE TO (bn) DUE TO (bo) DUE TO (bp) DUE TO (bq) DUE TO (br) DUE TO (bs) DUE TO (bt) DUE TO (bu) DUE TO (bv) DUE TO (bv) DUE TO (bw) DUE TO (bx) DUE TO (by) DUE TO (bz) DUE TO (ca) DUE TO (cb) DUE TO (cc) DUE TO (cd) DUE TO (ce) DUE TO (cf) DUE TO (cg) DUE TO (ch) DUE TO (ci) DUE TO (cj) DUE TO (ck) DUE TO (cl) DUE TO (cm) DUE TO (cn) DUE TO (co) DUE TO (cp) DUE TO (cq) DUE TO (cr) DUE TO (cs) DUE TO (ct) DUE TO (cu) DUE TO (cv) DUE TO (cw) DUE TO (cx) DUE TO (cy) DUE TO (cz) DUE TO (da) DUE TO (db) DUE TO (dc) DUE TO (dd) DUE TO (de) DUE TO (df) DUE TO (dg) DUE TO (dh) DUE TO (di) DUE TO (dj) DUE TO (dk) DUE TO (dl) DUE TO (dm) DUE TO (dn) DUE TO (do) DUE TO (dp) DUE TO (dq) DUE TO (dr) DUE TO (ds) DUE TO (dt) DUE TO (du) DUE TO (dv) DUE TO (dv) DUE TO (dw) DUE TO (dx) DUE TO (dy) DUE TO (dz) DUE TO (ea) DUE TO (eb) DUE TO (ec) DUE TO (ed) DUE TO (ee) DUE TO (ef) DUE TO (eg) DUE TO (eh) DUE TO (ei) DUE TO (ej) DUE TO (ek) DUE TO (el) DUE TO (em) DUE TO (en) DUE TO (eo) DUE TO (ep) DUE TO (eq) DUE TO (er) DUE TO (es) DUE TO (et) DUE TO (eu) DUE TO (ev) DUE TO (ev) DUE TO (ew) DUE TO (ex) DUE TO (ey) DUE TO (ez) DUE TO (fa) DUE TO (fb) DUE TO (fc) DUE TO (fd) DUE TO (fe) DUE TO (ff) DUE TO (fg) DUE TO (fh) DUE TO (fi) DUE TO (fj) DUE TO (fk) DUE TO (fl) DUE TO (fm) DUE TO (fn) DUE TO (fo) DUE TO (fp) DUE TO (fq) DUE TO (fr) DUE TO (fs) DUE TO (ft) DUE TO (fu) DUE TO (fv) DUE TO (fv) DUE TO (fw) DUE TO (fx) DUE TO (fy) DUE TO (fz) DUE TO (ga) DUE TO (gb) DUE TO (gc) DUE TO (gd) DUE TO (ge) DUE TO (gf) DUE TO (gg) DUE TO (gh) DUE TO (gi) DUE TO (gj) DUE TO (gk) DUE TO (gl) DUE TO (gm) DUE TO (gn) DUE TO (go) DUE TO (gp) DUE TO (gq) DUE TO (gr) DUE TO (gs) DUE TO (gt) DUE TO (gu) DUE TO (gv) DUE TO (gv) DUE TO (gw) DUE TO (gx) DUE TO (gy) DUE TO (gz) DUE TO (ha) DUE TO (hb) DUE TO (hc) DUE TO (hd) DUE TO (he) DUE TO (hf) DUE TO (hg) DUE TO (hh) DUE TO (hi) DUE TO (hj) DUE TO (hk) DUE TO (hl) DUE TO (hm) DUE TO (hn) DUE TO (ho) DUE TO (hp) DUE TO (hq) DUE TO (hr) DUE TO (hs) DUE TO (ht) DUE TO (hu) DUE TO (hv) DUE TO (hv) DUE TO (hw) DUE TO (hx) DUE TO (hy) DUE TO (hz) DUE TO (ia) DUE TO (ib) DUE TO (ic) DUE TO (id) DUE TO (ie) DUE TO (if) DUE TO (ig) DUE TO (ih) DUE TO (ii) DUE TO (ij) DUE TO (ik) DUE TO (il) DUE TO (im) DUE TO (in) DUE TO (io) DUE TO (ip) DUE TO (iq) DUE TO (ir) DUE TO (is) DUE TO (it) DUE TO (iu) DUE TO (iv) DUE TO (iv) DUE TO (iw) DUE TO (ix) DUE TO (iy) DUE TO (iz) DUE TO (ja) DUE TO (jb) DUE TO (jc) DUE TO (jd) DUE TO (je) DUE TO (jf) DUE TO (jg) DUE TO (jh) DUE TO (ji) DUE TO (jj) DUE TO (jk) DUE TO (jl) DUE TO (jm) DUE TO (jn) DUE TO (jo) DUE TO (jp) DUE TO (jq) DUE TO (jr) DUE TO (js) DUE TO (jt) DUE TO (ju) DUE TO (jv) DUE TO (jv) DUE TO (jw) DUE TO (jx) DUE TO (jy) DUE TO (jz) DUE TO (ka) DUE TO (kb) DUE TO (kc) DUE TO (kd) DUE TO (ke) DUE TO (kf) DUE TO (kg) DUE TO (kh) DUE TO (ki) DUE TO (kj) DUE TO (kk) DUE TO (kl) DUE TO (km) DUE TO (kn) DUE TO (ko) DUE TO (kp) DUE TO (kq) DUE TO (kr) DUE TO (ks) DUE TO (kt) DUE TO (ku) DUE TO (kv) DUE TO (kv) DUE TO (kw) DUE TO (kx) DUE TO (ky) DUE TO (kz) DUE TO (la) DUE TO (lb) DUE TO (lc) DUE TO (ld) DUE TO (le) DUE TO (lf) DUE TO (lg) DUE TO (lh) DUE TO (li) DUE TO (lj) DUE TO (lk) DUE TO (ll) DUE TO (lm) DUE TO (ln) DUE TO (lo) DUE TO (lp) DUE TO (lq) DUE TO (lr) DUE TO (ls) DUE TO (lt) DUE TO (lu) DUE TO (lv) DUE TO (lv) DUE TO (lw) DUE TO (lx) DUE TO (ly) DUE TO (lz) DUE TO (ma) DUE TO (mb) DUE TO (mc) DUE TO (md) DUE TO (me) DUE TO (mf) DUE TO (mg) DUE TO (mh) DUE TO (mi) DUE TO (mj) DUE TO (mk) DUE TO (ml) DUE TO (mm) DUE TO (mn) DUE TO (mo) DUE TO (mp) DUE TO (mq) DUE TO (mr) DUE TO (ms) DUE TO (mt) DUE TO (mu) DUE TO (mv) DUE TO (mv) DUE TO (mw) DUE TO (mx) DUE TO (my) DUE TO (mz) DUE TO (na) DUE TO (nb) DUE TO (nc) DUE TO (nd) DUE TO (ne) DUE TO (nf) DUE TO (ng) DUE TO (nh) DUE TO (ni) DUE TO (nj) DUE TO (nk) DUE TO (nl) DUE TO (nm) DUE TO (nn) DUE TO (no) DUE TO (np) DUE TO (nq) DUE TO (nr) DUE TO (ns) DUE TO (nt) DUE TO (nu) DUE TO (nv) DUE TO (nv) DUE TO (nw) DUE TO (nx) DUE TO (ny) DUE TO (nz) DUE TO (oa) DUE TO (ob) DUE TO (oc) DUE TO (od) DUE TO (oe) DUE TO (of) DUE TO (og) DUE TO (oh) DUE TO (oi) DUE TO (oj) DUE TO (ok) DUE TO (ol) DUE TO (om) DUE TO (on) DUE TO (oo) DUE TO (op) DUE TO (oq) DUE TO (or) DUE TO (os) DUE TO (ot) DUE TO (ou) DUE TO (ov) DUE TO (ov) DUE TO (ow) DUE TO (ox) DUE TO (oy) DUE TO (oz) DUE TO (pa) DUE TO (pb) DUE TO (pc) DUE TO (pd) DUE TO (pe) DUE TO (pf) DUE TO (pg) DUE TO (ph) DUE TO (pi) DUE TO (pj) DUE TO (pk) DUE TO (pl) DUE TO (pm) DUE TO (pn) DUE TO (po) DUE TO (pp) DUE TO (pq) DUE TO (pr) DUE TO (ps) DUE TO (pt) DUE TO (pu) DUE TO (pv) DUE TO (pv) DUE TO (pw) DUE TO (px) DUE TO (py) DUE TO (pz) DUE TO (qa) DUE TO (qb) DUE TO (qc) DUE TO (qd) DUE TO (qe) DUE TO (qf) DUE TO (qg) DUE TO (qh) DUE TO (qi) DUE TO (qj) DUE TO (qk) DUE TO (ql) DUE TO (qm) DUE TO (qn) DUE TO (qo) DUE TO (qp) DUE TO (qq) DUE TO (qr) DUE TO (qs) DUE TO (qt) DUE TO (qu) DUE TO (qv) DUE TO (qv) DUE TO (qw) DUE TO (qx) DUE TO (qy) DUE TO (qz) DUE TO (ra) DUE TO (rb) DUE TO (rc) DUE TO (rd) DUE TO (re) DUE TO (rf) DUE TO (rg) DUE TO (rh) DUE TO (ri) DUE TO (rj) DUE TO (rk) DUE TO (rl) DUE TO (rm) DUE TO (rn) DUE TO (ro) DUE TO (rp) DUE TO (rq) DUE TO (rr) DUE TO (rs) DUE TO (rt) DUE TO (ru) DUE TO (rv) DUE TO (rv) DUE TO (rw) DUE TO (rx) DUE TO (ry) DUE TO (rz) DUE TO (sa) DUE TO (sb) DUE TO (sc) DUE TO (sd) DUE TO (se) DUE TO (sf) DUE TO (sg) DUE TO (sh) DUE TO (si) DUE TO (sj) DUE TO (sk) DUE TO (sl) DUE TO (sm) DUE TO (sn) DUE TO (so) DUE TO (sp) DUE TO (sq) DUE TO (sr) DUE TO (ss) DUE TO (st) DUE TO (su) DUE TO (sv) DUE TO (sv) DUE TO (sw) DUE TO (sx) DUE TO (sy) DUE TO (sz) DUE TO (ta) DUE TO (tb) DUE TO (tc) DUE TO (td) DUE TO (te) DUE TO (tf) DUE TO (tg) DUE TO (th) DUE TO (ti) DUE TO (tj) DUE TO (tk) DUE TO (tl) DUE TO (tm) DUE TO (tn) DUE TO (to) DUE TO (tp) DUE TO (tq) DUE TO (tr) DUE TO (ts) DUE TO (tt) DUE TO (tu) DUE TO (tv) DUE TO (tv) DUE TO (tw) DUE TO (tx) DUE TO (ty) DUE TO (tz) DUE TO (ua) DUE TO (ub) DUE TO (uc) DUE TO (ud) DUE TO (ue) DUE TO (uf) DUE TO (ug) DUE TO (uh) DUE TO (ui) DUE TO (uj) DUE TO (uk) DUE TO (ul) DUE TO (um) DUE TO (un) DUE TO (uo) DUE TO (up) DUE TO (uq) DUE TO (ur) DUE TO (us) DUE TO (ut) DUE TO (uu) DUE TO (uv) DUE TO (uv) DUE TO (uw) DUE TO (ux) DUE TO (uy) DUE TO (uz) DUE TO (va) DUE TO (vb) DUE TO (vc) DUE TO (vd) DUE TO (ve) DUE TO (vf) DUE TO (vg) DUE TO (vh) DUE TO (vi) DUE TO (vj) DUE TO (vk) DUE TO (vl) DUE TO (vm) DUE TO (vn) DUE TO (vo) DUE TO (vp) DUE TO (vq) DUE TO (vr) DUE TO (vs) DUE TO (vt) DUE TO (vu) DUE TO (vv) DUE TO (vv) DUE TO (vw) DUE TO (vx) DUE TO (vy) DUE TO (vz) DUE TO (wa) DUE TO (wb) DUE TO (wc) DUE TO (wd) DUE TO (we) DUE TO (wf) DUE TO (wg) DUE TO (wh) DUE TO (wi) DUE TO (wj) DUE TO (wk) DUE TO (wl) DUE TO (wm) DUE TO (wn) DUE TO (wo) DUE TO (wp) DUE TO (wq) DUE TO (wr) DUE TO (ws) DUE TO (wt) DUE TO (wu) DUE TO (wv) DUE TO (wv) DUE TO (ww) DUE TO (wx) DUE TO (wy) DUE TO (wz) DUE TO (xa) DUE TO (xb) DUE TO (xc) DUE TO (xd) DUE TO (xe) DUE TO (xf) DUE TO (xg) DUE TO (xh) DUE TO (xi) DUE TO (xj) DUE TO (xk) DUE TO (xl) DUE TO (xm) DUE TO (xn) DUE TO (xo) DUE TO (xp) DUE TO (xq) DUE TO (xr) DUE TO (xs) DUE TO (xt) DUE TO (xu) DUE TO (xv) DUE TO (xv) DUE TO (xw) DUE TO (xx) DUE TO (xy) DUE TO (xz) DUE TO (ya) DUE TO (yb) DUE TO (yc) DUE TO (yd) DUE TO (ye) DUE TO (yf) DUE TO (yg) DUE TO (yh) DUE TO (yi) DUE TO (yj) DUE TO (yk) DUE TO (yl) DUE TO (ym) DUE TO (yn) DUE TO (yo) DUE TO (yp) DUE TO (yq) DUE TO (yr) DUE TO (ys) DUE TO (yt) DUE TO (yu) DUE TO (yv) DUE TO (yv) DUE TO (yw) DUE TO (yx) DUE TO (yy) DUE TO (yz) DUE TO (za) DUE TO (zb) DUE TO (zc) DUE TO (zd) DUE TO (ze) DUE TO (zf) DUE TO (zg) DUE TO (zh) DUE TO (zi) DUE TO (zj) DUE TO (zk) DUE TO (zl) DUE TO (zm) DUE TO (zn) DUE TO (zo) DUE TO (zp) DUE TO (zq) DUE TO (zr) DUE TO (zs) DUE TO (zt) DUE TO (zu) DUE TO (zv) DUE TO (zv) DUE TO (zw) DUE TO							

CERTIFICATE OF DEATH

307



Lee J. Henry

April 2, 1966, Arkansas Cemetery

Hoffman & Company, Baltimore, Md.

10. *Journal of the American Statistical Association*, 92(439):1089-1092, 1997.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3979

CERTIFICATE OF DEATH

Reg. Dist. No.

03918

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLY PRISCILLA Bounds</u>		4. DATE OF DEATH Month Day Year <u>March 14 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 22, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>R.D.# Princess Anne, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Alfred Hayman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Vincent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. W. Aubrey Bounds (Son) R.D.# 1 Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>Coronary Artery Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Sclerosis</u> DUE TO (c) <u>Coronary Artery Sclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/13</u> , 19 <u>60</u> , to <u>3/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>60</u> , and that death occurred at <u>3:54</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>3/14/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u>		Medical Center <u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Church Cemetery-Princess Anne, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>C. J. L. L. L.</u>			

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UNIVERSITY OF MICHIGAN LIBRARY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>wicomico</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>May</u> Last <u>Bradley</u>				4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>60</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>William H. Cooper</u>						14. MOTHER'S MAIDEN NAME <u>Maria Burford</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Miss Marian Bradley</u> Address <u>Sharptown, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic disease</u> (c) <u>Fractured left femur.</u> DUE TO (a) <u>Fractured left femur.</u> (b) <u>Arterio-sclerotic disease</u> (c) <u>Cerebral hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured left femur.</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at Maple Shade Nursing Home and fractured hip.</u>											
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>A. M.</u> <u>2-26-</u> <u>19 60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) (County) (State) <u>Mardela Springs Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Earl L. Royer</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-4-60</u>						DATE <u>3-4-60</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Firemens</u>				22d. LOCATION (City, town, or county) (State) <u>Sharptown, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>						ADDRESS <u>Sharptown, Md.</u>									
24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>									

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3982

CERTIFICATE OF DEATH

Reg. Dist. No.

03921

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROXANA DELAWARE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		d. STREET ADDRESS <u>46X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>ASHER</u> Middle <u>CAREY</u> Last <u>CAREY</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/52</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auctioneer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES M. CAREY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE GRAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>MRS. MAC CAREY ROXANA DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Coronary artery disease.</u> DUE TO (c) <u>None.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 March</u> , 19 <u>60</u> , to <u>16 March</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>16 March</u> , 19 <u>60</u> , and that death occurred at <u>11:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph C. Fitzgerald</u>		DATE SIGNED <u>J. C. Fitzgerald M.D.</u>	
PHYSICIAN'S NAME (Type) <u>707 Camden Ave. Salisbury.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROXANA Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>ROXANA Del.</u>
23. BURIAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u>		ADDRESS <u>Freetown</u>	
24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram.</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

2. The second of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

3. The third of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

4. The fourth of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

5. The fifth of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

6. The sixth of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

7. The seventh of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

8. The eighth of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

9. The ninth of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

10. The tenth of the above mentioned items is a copy of the report of the committee on the subject of the proposed amendment to the charter of the city of New York, which was adopted by the board of directors of the Standard Industrial Company on the 15th day of January, 1902.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3953
CERTIFICATE OF DEATH

03922

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>50 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Chambers</u> Last <u>Chambers</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1960</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-83</u>	9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	IF UNDER 24 HRS. <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired store employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Chambers</u>				14. MOTHER'S MAIDEN NAME <u>?? Stutcenburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Deer's Head Records</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding duodenal ulcer</u> 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, general</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-8-1960</u> to <u>3-29-1960</u> , that (I) (we) last saw the deceased alive on <u>3-29-1960</u> and that death occurred at <u>1:55 a.m.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Lee L. Lawry</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-29-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>				22d. ADDRESS <u>Deer's Head State Hospital</u> <u>Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 1 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		23d. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moon + Son</u> ADDRESS <u>Denton Md</u>				25a. REC'D BY REGISTRAR <u>APR 4 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO THE HONORABLE ATTORNEY GENERAL
 UNITED STATES DEPARTMENT OF JUSTICE
 WASHINGTON, D. C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
 Yours very truly,
 J. Edgar Hoover

Special Agent in Charge

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 WKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Francis Marion Chatham</u>				4. DATE OF DEATH <u>March 22 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 29, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER</u>		11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPHUS CHATHAM</u>				14. MOTHER'S MAIDEN NAME <u>DRUSCILLA MESSICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>SP.A. AMER</u>		INFORMANT <u>MRS. LILLIAN M. CHATHAM - SAME</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary Tract Infection, Arteriosclerotic Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>3/8</u> , 19 <u>60</u> , to <u>3/22</u> , 19 <u>60</u> that I lost saw the deceased alive on <u>3/21</u> , 19 <u>60</u> , and that death occurred at <u>2:54</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Schure</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Ind.</u>		DATE SIGNED <u>3/23/60</u>			
PHYSICIAN'S NAME (Type) <u>David J. Schure</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/24/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>SALISBURY MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>HILL & JOHNSON CO.</u> ADDRESS <u>SALISBURY, MD.</u>		24. REC'D BY REGISTRAR <u>MAR 23 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANAGEMENT OF THE ORAL AND MAXILLOFACIAL SURGERY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1

3985

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03924

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 705 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Enoch Last Collison		4. DATE OF DEATH Month March Day 28 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1875
9. AGE (In years last birthday) 84 yrs.		10. UNDER 1 YEAR Months 8 Days 14 Hours 4 Min.	11. UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Collison		14. MOTHER'S MAIDEN NAME Mary Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. -	
17. INFORMANT Deer's Head Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/23 19 58 to 3/28 19 60 , that (I) (we) lost the deceased alive on 3/28 19 60 , and that death occurred at 5:30 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE Lee L. Lawry		22b. DATE SIGNED 3/29/60	
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D.		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 2/60	
23c. NAME OF CEMETERY OR CREMATORY Denton		23d. LOCATION (City, town, or county) (State) Denton Md	
24. FUNERAL DIRECTOR'S SIGNATURE J. Eugene Moorhead		25a. REC'D BY REGISTRAR APR 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. DATE APR 4 '60	

STATE OF TEXAS
COUNTY OF DALLAS

1905

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film 259.3/23/60 1b

CERTIFICATE OF DEATH

Reg. Dist. No.

03925

3986

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>714 HOWARD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGIE Cooper</u>				4. DATE OF DEATH Month Day Year <u>March 16 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1894</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HAMPLIN BUTER</u>			14. MOTHER'S MAIDEN NAME <u>CHARLOTTE TAYLOR</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u> INFORMANT Address <u>Micie Bullingham - Leilmor</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebro Vascular Accident</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec -</u> , 19 <u>55</u> , to <u>3/16/60</u> , that I last saw the deceased alive on <u>3/16/60</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Earl Doye</u>		M.D. <u>Salisbury Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>3/16/60</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W-S-Memorial Co - Leilmor, Leil</u>		22d. LOCATION (City, town, or county) (State) <u>Leilmor Leil</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-S-Memorial Co - Leilmor, Leil</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-1000

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]



3987

CERTIFICATE OF DEATH

Reg. Dist. No.

03926

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>118 W. Locust</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FRANKLIN</u> Last <u>Coulbourn</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 16</u> <u>1872</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Josuha J. Coulbourn</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Chatham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes SPANISH-American</u>		16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Mrs. John Coulbourn</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>52</u> to <u>3/12</u> 19 <u>60</u> that I last saw the deceased alive on <u>3/12</u> 19 <u>60</u> , and that death occurred at <u>5:25</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Fred R. Gramse</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse</u>				DATE SIGNED <u>Salisbury, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-14-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Gramse</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3937

STATE OF TEXAS

COMMISSIONER OF LAND

LAND AND STATE DEPARTMENT OF HEALTH - BIRMINGHAM

1914

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
3988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 03927											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula Sanatorium</u>						d. STREET ADDRESS <u>706 Rose St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Delores Andrews Cuff</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-11-21</u>		9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Fla</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Andrews</u>						14. MOTHER'S MAIDEN NAME <u>William Cuff</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>William Cuff</u> Address <u>706 Rose St</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Atelectasis</u> DUE TO (c) <u>Aspiration</u> hours											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Earl H. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-18-60</u>			
EXAMINER'S NAME (Type) <u>Earl H. Royer</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenway</u>		22d. LOCATION (City, town, or county) (State) <u>Fla</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Decker McWee</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrash</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH-CAMBRIDGE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3989

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>36 days</u> X <u>Delmar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>206 Railroad Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>BYRON</u> <u>Clark</u> <u>Cugler</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>11</u> <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-1919</u>	
9. AGE (In years lost birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FOOD</u>		11. BIRTHPLACE (State or foreign country) <u>CRISFIELD MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WM L. CUGLER</u>				14. MOTHER'S MAIDEN NAME <u>ELSIE M. HINNMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>221-05-9815</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> DUE TO <u>chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-11</u> , 19 <u>60</u> , to <u>3-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>60</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William S. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u>				DATE SIGNED <u>3-11-60</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co. - Delmar, Del</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3990

CERTIFICATE OF DEATH

Reg. Dist. No.

03929

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN Ib 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak 20X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Middle J. Last Cullen				4. DATE OF DEATH Month March Day 3 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4 1872	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	
10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Australia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lawrence Cullen				14. MOTHER'S MAIDEN NAME Margaret Whalen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. -		INFORMANT Deer's Head Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Arteriosclerosis, general							20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>							20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)							21. I certify that I attended the deceased from Feb. 4 , 1960, to March 3 , 1960, that I last saw the deceased alive on March 3 , 1960, and that death occurred at 8:15 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/4/60							ACTUAL SIGNATURE Lee L. Lawry M.D.
PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D. Salisbury, Maryland							22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF Mar. 5, 1960							22c. NAME OF CEMETERY OR CREMATORY Gods Hill Cemetery
22d. LOCATION (City, town, or county) (State) Washington, D.C.							23. FUNERAL DIRECTOR'S SIGNATURE A. Hamilton Harrison, St. Michael's ADDRESS md.
24a. REC'D BY REGISTRAR DATE MAR 8 '60							24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3990

11232

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

3991

CERTIFICATE OF DEATH

03930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>				d. STREET ADDRESS <u>WASHINGTON</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK AUSTIN CULVER SR</u>				4. DATE OF DEATH Month Day Year <u>march-18-1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 14, 1887</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAGISTRATE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MUNICIPAL</u>		11. BIRTHPLACE (State or foreign country) <u>PRINCESS ANNE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>GEORGE CULVER</u>			
14. MOTHER'S MAIDEN NAME <u>ADELIN C MILLER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give way or dates of service)			
16. SOCIAL SECURITY NO. <u>214-32-7455</u>				INFORMANT Address <u>MRS. F. A. CULVER BERLIN, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1</u> DUE TO <u>Cor pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic pulmonary emphysema</u> DUE TO (c) <u>"</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>3-4</u> , 19 <u>60</u> , to <u>3-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-18</u> , 19 <u>60</u> , and that death occurred at <u>7:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willie R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>3-18-60</u>			
PHYSICIAN'S NAME (Type) <u>Willie R. Ellis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burdage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. K...</u>	

Page 4

24 hours after death.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH

THIS IS TO CERTIFY that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Department of Health of the State of California.

WITNESSED my hand and the seal of the Department of Health at the City of Sacramento, this 1st day of January, 1911.

JOHN W. HARRIS, Secretary of the Department of Health.

Attest:
J. W. Harris, Secretary of the Department of Health.

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3992

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03931

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wic</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>9 Mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deers Head Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Ardis Dallas</u>				4. DATE OF DEATH Month Day Year <u>3-12-60</u> 19			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-24-06</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ind Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David H Dallas</u>				14. MOTHER'S MAIDEN NAME <u>JANE S Ardis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>George Dallas</u> Address <u>Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>16 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-11-59</u> to <u>3-12</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3-12-1960</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Lee L Lawry</u>				22b. DATE SIGNED <u>3-12-1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>LEE L. LAWRY</u>				22d. ADDRESS <u>Salisbury, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>3-16-1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>West Laurel Hill Cem</u>				23d. LOCATION (City, town, or county) (State) <u>Phila, MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 15 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>							

CERTIFICATE OF MARRIAGE

1903

(1)

(1)

1903

1903

3993

CERTIFICATE OF DEATH

03932

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb 33 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				d. STREET ADDRESS 1 First Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Last Day				4. DATE OF DEATH Month March Day 6 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/27/1884		9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Day				14. MOTHER'S MAIDEN NAME Eliza			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-18-6434		INFORMANT Deer's Head Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary carcinoma with metastases 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from Feb. 2 , 19 60 , to March 6 , 19 60 , that I last saw the deceased alive on March 6 , 19 60 , and that death occurred at 10:30P , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/7/60			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/ 10/1960		22c. NAME OF CEMETERY OR CREMATORY green acres		22d. LOCATION (City, town, or county) (State) Salisbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton O. Stewart				ADDRESS Salisbury Md.		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF THE
COMMISSIONER OF HEALTH
OF THE DISTRICT OF COLUMBIA
FOR THE YEAR 1900

THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
BUREAU OF DISEASES
WASHINGTON, D. C.
1901

REPORT OF THE
COMMISSIONER OF HEALTH
OF THE DISTRICT OF COLUMBIA
FOR THE YEAR 1900

THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
BUREAU OF DISEASES
WASHINGTON, D. C.
1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

3934

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03933

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 64 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Delmar (Rt. #3)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEER'S HEAD STATE HOSPITAL				d. STREET ADDRESS Rt. #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Manie Middle -- Last Dennis				4. DATE OF DEATH Month 3 Day 18 Year 19 60			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-72	
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) unknown Melson, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME unknown Joseph Hastings				14. MOTHER'S MAIDEN NAME Harriett unknown Harriett Ellen Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Deer's Head Records				Address Mr. Linwood Ward (Grand-Son) 424 W. Commerce St. Smyrna, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Wicomico		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 1-11 19 60 , to 3-18 1960 , that (I) (we) last saw the deceased alive on 3-18 1960 , and that death occurred at 12:55 a.m. M, from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve, M. D.				22b. DATE 3-18-60			
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head State Hospital Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		Mar. 21, 1960		Whitesville Line Cemetery		(Wicomico Co. Maryland)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE MAR 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kiana							

CERTIFICATE OF DEATH

3904

Blank form with faint lines and text, including a large circular stamp on the right side.

3995

CERTIFICATE OF DEATH

03934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA General Hospital</u>		1d. STREET ADDRESS <u>QUANTICO Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SAMFORD KENT DYKES</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALONZA DYKES</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> INFORMANT <u>JAMES M. DYKES - Sharptown, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia. Left lower lobe</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bacterial pneumonia</u> DUE TO (c) <u>Myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fisher, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Und. 3-8-60</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM H. FISHER, JR.</u>		<u>SALISBURY, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/7/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u> ADDRESS <u>SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3996 CERTIFICATE OF DEATH

03935

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 10mos.23Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head state hospital			d. STREET ADDRESS Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle ---- Last Elliott			4. DATE OF DEATH Month March Day 23 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1891		9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Warrington			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME Mary C. Warrington			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I		
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			17. INFORMANT Hospital Records -- Salisbury, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Gangrene Left Leg DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 3 Months 17 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/20/59 to 3/23/19 60 , that (I) (we) last saw the deceased alive on 3/23/19 60 , and that death occurred at 8:15 from the causes and on the date stated above.					
22a. SIGNATURE L. Maldve		22b. DATE P.M. M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> March 23, 1960		22c. PHYSICIAN'S NAME (Type) L. Maldve, M.D.	
22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-26-60		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	
23d. LOCATION (City, town, or county) (State) Cambridge, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Faw. Home, Cambridge, Md.		25a. REC'D BY REGISTRAR MAR 28 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

4032

CERTIFICATE OF DEATH

03936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALLEN</u>				c. LENGTH OF STAY IN TB <u>42 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HERBERT</u> First <u>PENN</u> Middle <u>ELZEY</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CAR SALESMAN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HARVEY ELZEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY TUBBS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-10-7015</u>		17. INFORMANT Address <u>MRS H.P. ELZEY, SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis with</u> <u>260x</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Atherosclerosis with Chronic Brain Syndrome</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 17, 1957</u> , to <u>March 9, 1960</u> , that I last saw the deceased alive on <u>March 2, 1960</u> , and that death occurred at <u>8:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D. <u>SALISBURY, MARYLAND</u>				DATE SIGNED <u>3-1960</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr. Five BLUFF RD., SALISBURY, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-12-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ALLEN Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>ALLEN, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co., Salisbury, Md</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

3997

CERTIFICATE OF DEATH

Reg. Dist. No.

p3937

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>23X 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>KEYSER POINT RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK HOWARD EVANS</u>				4. DATE OF DEATH Month Day Year <u>MARCH 17 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 19 1895</u>		9. AGE (In years lost birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MUNICIPAL</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CORNELIUS EVANS</u>				14. MOTHER'S MAIDEN NAME <u>ELAYRA RICHARDSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>213-05-0802</u>		INFORMANT Address <u>Mrs. F. H. EVANS, OCEAN CITY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>" Atherosclerosis</u> lying cause lost. (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>60</u> to <u>3/17</u> , 19 <u>60</u> (that I last saw the deceased alive on <u>3/17</u> , 19 <u>60</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul J. Gilman</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury Md. Mar. 17, 1960</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna Burbage</u>				ADDRESS <u>Berlin, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
ISM 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4033

CERTIFICATE OF DEATH

Reg. Dist. No.

03938

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela		c. LENGTH OF STAY IN 1b 18 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home		d. STREET ADDRESS 220 Hazel Ave.,	
3. NAME OF DECEASED (Type or print) First NANCY Middle ELIZABETH Last FIELDS		4. DATE OF DEATH Month 3 Day 16 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Minos Handy White		14. MOTHER'S MAIDEN NAME Mary Ann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Madelyn F. Benham, Same	
17. INFORMANT Address Mrs. Madelyn F. Benham, Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Oct 1958 , to Mar 16 1960 , that I last saw the deceased alive on Mar 16 1960 , and that death occurred at 2:45 P. M, from the causes and on the date stated above.	
ACTUAL SIGNATURE J. S. Kuhlman M.D.		ADDRESS (Street, city or town, state) Sharptown, Maryland	
DATE SIGNED 3-17-1960		PHYSICIAN'S NAME (Type) Dr. H.S. Kuhlman Sharptown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-1960	
22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		22d. LOCATION (City, town, or county) (State) Shad Point, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE MAR 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MASSACHUSETTS DEPARTMENT OF RECREATION AND LEISURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3998

CERTIFICATE OF DEATH

Reg. Dist. No.

03989

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 927 East Church St	
3. NAME OF DECEASED (Type or print) WILLIAM FRANCIS FOOKS		4. DATE OF DEATH MARCH 4th 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee of -State of Delaware)		10b. KIND OF BUSINESS OR INDUSTRY Worcester Co. Md.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Affria Fooks		14. MOTHER'S MAIDEN NAME Annie Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Helen A. Fooks (Wife)		Address 927 E. Church St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 8 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 3/4 , 19 60 , that I last saw the deceased alive on 3/4/60 , 19 60 , and that death occurred at 10:46 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED March 5 / 1960			
ACTUAL SIGNATURE Fred R. Gramse M.D.		PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 7 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Gramse			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
VS A15 (4)
15M 10/57

082

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139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03940

3999

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle WILLIAM Last FOX		4. DATE OF DEATH Month 3 Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1891
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months 6 Days 8 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Publishing	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph T. Fox		14. MOTHER'S MAIDEN NAME Mary A. Berlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 097-09-8932	
INFORMANT Mrs. Mary A. Fox Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) dissecting aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aortic arteriosclerosis (atherosclerosis) DUE TO (c) sev. years		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/19 , 19 60 , to 3/23 , 19 60 , that I last saw the deceased alive on 3/23 , 19 60 , and that death occurred at 12:15 A.M. from the causes and on the date stated above.		DATE SIGNED 3-25-60	
ACTUAL SIGNATURE Harry Mattay M.D.		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. Harry Mattay		Camden Ave., Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-1960	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF BIRTH

1900

1900

Full Name

Full Name

Address

Address

Place of Birth

Place of Birth

Date of Birth

Date of Birth

Sex

Sex

Signature of Registrar

Signature of Registrar

Witness Signature

Witness Signature

[Faint, illegible text, possibly a signature or stamp]

Registrar's Office

City and State

County

Year

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, Film G259 3/21/60 1b
4000

CERTIFICATE OF DEATH

03941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle V. Last Gale				4. DATE OF DEATH Month March Day 5 Year 1960			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 15, 1878	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 5 Days mo Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Fredrick Gale				14. MOTHER'S MAIDEN NAME Bridget Ballard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Levin Gale R.F.D. 1 Quantico Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 446x DUE TO Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chlorosclerosis (c) 5 mo. indefinite							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5 Oct 59 to 5 Mar 60 , that I last saw the deceased alive on 5 Mar 60 , and that death occurred at 7 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 11 March 60							
ACTUAL SIGNATURE E.A. Funnell M.D.				PHYSICIAN'S NAME (Type) E.A. Funnell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/1960		22c. NAME OF CEMETERY OR CREMATORY Church		22d. LOCATION (City, town, or county) (State) Quantico Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton E. Stewart, Salisbury Md.				24a. REC'D BY REGISTRAR DATE MAR 16 '60			
24b. REGISTRAR'S SIGNATURE Clinton E. Stewart							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4001
CERTIFICATE OF DEATH

03942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chance</u> <u>19X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head state hospital</u>		d. STREET ADDRESS <u>---</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Elizabeth</u> Last <u>Gladden</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David James</u>		14. MOTHER'S MAIDEN NAME <u>Louise</u> SHORES <u>SHORES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Hospital Records -- Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with Hemiplegia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u> <u>10 Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/25/</u> , 19 <u>60</u> , to <u>3/12/</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/12/</u> , 19 <u>60</u> , and that death occurred at <u>9:55AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lee L. Lawry</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR-14-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CHANCE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leroy H. Webster</u>		ADDRESS <u>Princess Anne</u>	
24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

CERTIFICATE OF DEATH

1004

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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4002
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03943

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 182 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS RFD # 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle Mae Last Groves		4. DATE OF DEATH Month March Day 21 Year 19 60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1892
9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67		IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Own-Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Brooks		14. MOTHER'S MAIDEN NAME Rachel Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Deer's Head Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of urinary bladder with generalized metastases. 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1959 to March 21, 1960 , that (I) (we) last saw the deceased alive on March 20, 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE 6:30 A.M.	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/24/60	
23c. NAME OF CEMETERY OR CREMATORY mt Pleasant		23d. LOCATION (City, town, or county) (State) Indown md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward J. Fallowe		25a. REC'D BY REGISTRAR MARTIN	
25b. REGISTRAR'S SIGNATURE Arthur S. Fraws		25c. DATE MAR 28 '60	

CLINICAL OF DATA

4004

1994

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03944

4003

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Neavitt</u>	
c. LENGTH OF STAY IN 1b <u>558 days</u>		d. STREET ADDRESS <u>--</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>L.</u> Last <u>Haddaway</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-81</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wayman</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Deer's Head Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis, general, severe</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of colon.</u>			
INTERVAL BETWEEN ONSET AND DEATH Years _____ Years _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> 19 <u>58</u> to <u>3/8</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/8</u> 19 <u>60</u> and that death occurred at <u>11:10 p.m.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>L. V. Maldve</u>		22b. DATE SIGNED <u>3/9/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-11-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Neavitt Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Neavitt Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hamilton Harrison, Jr. Michael</u>		25. REC'D BY REGISTRAR <u>MAR 14 '60</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

1000

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

REGISTRAR

SIGNATURE

DATE

PLACE

REGISTRAR

SIGNATURE

DATE

PLACE

CERTIFICATE OF DEATH

Reg. Dist. No.

03945

4004

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R.F. Dot #2, Dorsey Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rogers James HAYWARD</u>		4. DATE OF DEATH Month Year <u>MARCH 9 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1960</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion Perry</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Hayward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Immaturity (Birth wt 375 gms)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> DUE TO <u>None</u> (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 9, 1960</u> to <u>March 9, 1960</u> , that I last saw the deceased alive on <u>March 9, 1960</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>3/11/60</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/14/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Huston Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton or Stewart Salisbury</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082222XVO

TO THE HONORABLE THE COMMISSIONERS OF THE LAND OFFICE
ALBANY, N. Y.

SIR:

I have the honor to acknowledge the receipt of your letter of the 27th inst. in relation to the above matter.

I am sorry to hear that you are unable to find the original of the deed in question. I have, however, been able to locate the same in the records of the County of Albany.

The deed in question is a conveyance of a certain tract of land, situate in the County of Albany, to the State of New York, and is dated the 1st day of January, 1899.

I am, Sir, very respectfully,
Yours truly,
J. B. ALLEN,
Attorney General.

4005

CERTIFICATE OF DEATH

Reg. Dist. No.

03946

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Private Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle CORRAN Last HEARN		4. DATE OF DEATH Month MARCH Day 30th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1884
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ins. Salesman		10b. KIND OF BUSINESS OR INDUSTRY (Insurance)	
11. BIRTHPLACE (State or foreign country) Whitesville, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Hearn		14. MOTHER'S MAIDEN NAME (Margaret Elizabeth Miller)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. H. Clyde Hearn (Son) % Central Hotel Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1960 , 19 3/30 , 19 60 , that I last saw the deceased alive on 3/29/60 , 19 60 , and that death occurred at 11:30P , from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred R. Gramse		DATE SIGNED Mar. 31, 1960	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse		S. Division St Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 2, 1960	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR APR 4 '60	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur L. Hearn	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

1914

of Public Health

Division

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

Division of Public Health

4034

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. LENGTH OF STAY IN 1b 25 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cemetery st/				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Maggie Elizabeth Henry				4. DATE OF DEATH Month Day Year March 5 19 60			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 13, 1892	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY (Own Home)		11. BIRTHPLACE (State or foreign country) Dorchester County		12. CITIZEN OF WHAT COUNTRY? US.	
13. FATHER'S NAME John Dunn				14. MOTHER'S MAIDEN NAME Ellen Tull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Joseph Mitchell Sharptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Myocardial Infarction DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/11 , 19 54 , to 3/5 , 19 60 , that I last saw the deceased alive on 3/5 , 19 60 , and that death occurred at 2:44 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharptown, Md. DATE SIGNED Samuel H. Hef							
ACTUAL SIGNATURE Charles M. Mays M.D. Samuel H. Hef							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-60		22c. NAME OF CEMETERY OR CREMATORY Firemens		22d. LOCATION (City, town, or county) (State) Sharptown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Smith Funeral Home				ADDRESS Sharptown, Md.		24a. REC'D BY REGISTRAR MAR 10 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03948

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Pen Gen Hospital		d. STREET ADDRESS 633 Homer St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle WILLIAM Last HILL		4. DATE OF DEATH Month MARCH Day 7th Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby	8. DATE OF BIRTH Feb. 7, 1959
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 0	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William W. Hill		14. MOTHER'S MAIDEN NAME Mabel M. Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. William W. Hill (Father)		Address 633 Homer St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500X DUE TO Acute laryngeal Stenosis - Bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 10, 1960	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR MAR 10 '60	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Carlton S. Kraw	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
4007
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
03949
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3430 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>Anna</u> Last <u>Holt</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-73</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>		11. AGE (In years last birthday) <u>87</u> yrs.		12. IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>			
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W. Humphreys</u>				14. MOTHER'S MAIDEN NAME <u>Leah E. Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mrs. Pauline H. Tignor</u>				18. ADDRESS <u>434 Md Ave. Norfolk 8 Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Arteriosclerosis, generalized</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>---</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from <u>11/6/50</u> to <u>3/28</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>60</u> , and that death occurred at <u>1:30</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. V. Maldve</u>				22b. DATE SIGNED <u>---</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>				22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Mar. 30, 1960</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				25a. REC'D BY REGISTRAR <u>MAR 31 '60</u>			
ADDRESS <u>SALISBURY MARYLAND</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

MEDICAL CERTIFICATION

2

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SECRET

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1035

NAME OF DECEASED		DATE OF DEATH	
JAMES E. JONES		JAN 1 - 1961	
RESIDENCE		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
AGE		SEX	
35		M	
RACE		EDUCATION	
WHITE		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		CERTIFICATE NO.	
NATURAL		1035	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. E. JONES		J. E. JONES	
DATE		DATE	
JAN 1 - 1961		JAN 1 - 1961	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4008

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 14 Film G259 3-28-60 et

CERTIFICATE OF DEATH

03951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Jesse</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>6 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		46x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>407 Winder Street (home)</u>				d. STREET ADDRESS <u>RDY MR Shiloh Church</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>G. Johnson</u> Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Neal Harkins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Duffy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>MARLYN RICHARDSON, WINTER ST, SALISBURY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neoplasm Rt. Lung with Pleural Effusion</u> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Effusion</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September, 1960</u> , to <u>March 20, 1960</u> , that I last saw the deceased alive on <u>March 18, 1960</u> , and that death occurred at <u>10:25</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Maryland</u>		DATE SIGNED <u>3/22/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Williams</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

1905

10

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
DATE _____		TIME _____	

For use in the State of Maryland only. This certificate is to be filled out by the physician attending the deceased, or by the registrar of the health department, or by the coroner, or by the justice of the peace, or by the minister of the Gospel, or by the lay member of the church, or by the family of the deceased, or by any other person who may be authorized by the health department. This certificate is to be filed in the office of the registrar of the health department, or in the office of the coroner, or in the office of the justice of the peace, or in the office of the minister of the Gospel, or in the office of the lay member of the church, or in the office of the family of the deceased, or in any other office where it may be filed. This certificate is to be used for the purpose of recording the death of the deceased, and for the purpose of obtaining a burial permit, or for the purpose of obtaining a certificate of death, or for the purpose of obtaining a certificate of burial, or for the purpose of obtaining a certificate of interment, or for the purpose of obtaining a certificate of cremation, or for the purpose of obtaining a certificate of disposition of the remains of the deceased.

4036

CERTIFICATE OF DEATH

03952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle ANN Last KIRWAN		4. DATE OF DEATH Month March Day 1 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. Wainwright		14. MOTHER'S MAIDEN NAME Georgia Ann Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Morgan Kirwan, Tyaskin, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cardiac hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Nil	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) previous cardiac hemorrhage.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/29/60 , 19 60 , to 3/1/60 , 19 60 , that I last saw the deceased alive on 2/29/60 , 19 60 , and that death occurred at 6:11 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Early Beardsley		DATE SIGNED 3/2/60	
PHYSICIAN'S NAME (Type) Salisbury		M.D. Salisbury	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/60	
22c. NAME OF CEMETERY OR CREMATORY Bivalve Cem.		22d. LOCATION (City, town, or county) (State) Tyaskin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. D. W. Person		ADDRESS Bivalve, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03953

4037

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barnetta</u> Middle <u>Lee</u> Last <u>Larmore</u>				4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-63</u>	9. AGE (In years last birthday) <u>97</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Dickerson</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Larmore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Edgar Langrell, Biverville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive C.V. Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin C.m.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. J. Biverville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. RESIDENCE	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN	
19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF CHURCH		21. SIGNATURE OF FUNERAL HOME	
22. SIGNATURE OF BURIAL PLACE		23. SIGNATURE OF CEMETERY		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF CREMATION		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

CERTIFICATE OF DEATH

Reg. Dist. No.

03954

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS 622 Dover St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle HERMAN Last LAYTON		4. DATE OF DEATH Month MARCH Day 23rd Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 8 Days 14	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee-Md		10b. KIND OF BUSINESS OR INDUSTRY State Roads Dept.	
11. BIRTHPLACE (State or foreign country) Pittsville, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Thomas Layton		14. MOTHER'S MAIDEN NAME Annie Elizabeth Farlow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS 622 Dover St		18. ADDRESS Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease 422.2 DUE TO (b) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 12 , 19 53 , to Mar. 23 , 19 60 , that I last saw the deceased alive on 3-23 , 19 60 , and that death occurred at 6:50A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED Mar. 24, 1960			
ACTUAL SIGNATURE William R. Ellis Jr M.D.		DATE SIGNED Mar. 24, 1960	
PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr		Medical Center Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 25, 1960	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery-Walston-R.D. Parsonsburg, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 22 a,b,c,&d Film G258 3/11/60 iwk
4010
CERTIFICATE OF DEATH

Reg. Dist. No.

03955

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
c. LENGTH OF STAY IN 1b <u>8 mos. 24da.</u>				d. STREET ADDRESS <u>RFD #3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>---</u> Last <u>LeCompte</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>		IF UNDER 24 HRS. Months <u>74</u> Days <u>74</u> Hours <u>74</u> Min. <u>74</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>-----</u>				14. MOTHER'S MAIDEN NAME <u>-----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>				16. SOCIAL SECURITY NO. <u>---</u>			
INFORMANT <u>Hospital Records -- Salisbury, Maryland</u>				Address <u>---</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchia Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10/</u> , 19 <u>59</u> , to <u>3/4/</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/4/</u> , 19 <u>60</u> , and that death occurred at <u>7:10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Maldve</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>---</u>	
PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service, Cambridge, Md.</u>				ADDRESS <u>---</u>		24a. REC'D BY REGISTRAR <u>---</u>	
DATE <u>---</u>				24b. REGISTRAR'S SIGNATURE <u>---</u>		DATE <u>MAR 8 '60</u>	

RECEIVED

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar upon burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
4011 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Route # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Deborah Anne Lewis</u>				4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-59</u>		9. AGE (In years last birthday) <u>—</u> yrs.	IF UNDER 1 YEAR Month <u>3</u> Days <u>—</u> Hours <u>—</u> Min.	IF UNDER 24 HRS. Hours <u>—</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>—</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Barbara Lewis</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause lost. DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , <u>Accident</u> <input type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined cause</u> <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3-21-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. Baker</u>				ADDRESS <u>Indecest</u>		24a. REC'D BY REGISTRAR <u>MAR 23 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>			

2082183XV5

BALTIMORE, 18

4012 Item 2 Film G258 3-14-60 et

CERTIFICATE OF DEATH

03957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> <u>Dorchester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>John B. Parsons Home</u>				d. STREET ADDRESS <u>300 Belvidere Ave.</u> <u>John B. Parsons Home</u>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>LOUISE</u> Last <u>MEEKINS</u>				4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5, 1868</u>	
9. AGE (In years last birthday) yrs. <u>91</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>60</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Nurse</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Nurse</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Joseph Pfister</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Noah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>John B. Parsons Home Records. Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic vascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>3-5</u> 1960 , that I last saw the deceased alive on <u>2-25</u> 1960 , and that death occurred at <u>10:30 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>3-7-1960</u>							
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley East Main St., Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hill & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

24 hours after death. Page 4
 The low requires that the death certificate be executed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 03958									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12.5km</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Ty 2.5km</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Evans</u> Middle <u>Carlisle</u> Last <u>Mezick</u>					4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1960</u>				
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/7/1898</u>		9. AGE (In years and birthday) <u>62</u> yrs.	
						IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Luther Mezick</u>					14. MOTHER'S MAIDEN NAME <u>Carrie Robertson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>P</u>		17. INFORMANT <u>Evan Mezick, Baltimore, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> (c) <u>Arteriosclerotic heart disease</u> DUE TO <u>Arteriosclerotic heart disease</u> cause lost. <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> Years <u></u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Robertson Private Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Ty 2.5km, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Massick, Bladue, Md.</u> ADDRESS <u></u>					24a. REC'D BY REGISTRAR <u>MAR 15 '60</u> DATE <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		OCCUPATION _____		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____		PHYSICAL EXAMINATION _____	
TOXICOLOGY _____		PATHOLOGICAL FINDINGS _____		LABORATORY TESTS _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____		SIGNATURE OF JURY _____	
TITLE OF EXAMINER _____		TITLE OF WITNESS _____		TITLE OF JURY _____	
DATE OF EXAMINATION _____		DATE OF DEATH _____		DATE OF CERTIFICATE _____	

This certificate is to be filed in the office of the State Department of Health, Baltimore, Maryland, and a copy thereof to be furnished to the proper authorities.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4039

CERTIFICATE OF DEATH

03959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Delmar		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3		d. STREET ADDRESS R.D.# 3	
3. NAME OF DECEASED (Type or print) First LYDIA Middle FRANCES Last MILLS		4. DATE OF DEATH Month MARCH Day 16th Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 2 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Athol-Wico.Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Hatton		14. MOTHER'S MAIDEN NAME Marth Ellen Kennerly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Talbot F. Mills (Son) Spring Hill Rd Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 1960 and that death occurred at March 16, 1960 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED March 17, 1960	
ACTUAL SIGNATURE Dr. L.V. Sohler M.D.		PHYSICIAN'S NAME (Type) Dr. L.V. Sohler Delmar, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE MAR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1000

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 15, 1900	
AGE		SEX	
65		Male	
BIRTH PLACE		CITY	
Maryland		Baltimore	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
EDUCATION		PLACE OF DEATH	
High School		Home	
MARRIAGE		DATE OF BURIAL	
Married		JANUARY 16, 1900	
SPOUSE'S NAME		BURIAL PLACE	
Mary H. Harris		Catholic Cemetery	
DATE OF INTERVIEW		INTERVIEWER	
JANUARY 15, 1900		J. H. Harris	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
James H. Harris		Mary H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 15, 1900		JANUARY 15, 1900	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03960

Reg. Dist. No.

4013

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X DELMAR</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>RD # 3</u>					
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>11-3-1888</u>		9. AGE (In years last birthday) <u>71</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Delmar, Ind</u>					
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Isaac Heam</u>							
14. MOTHER'S MAIDEN NAME <u>Bessie Bounds</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>							
16. SOCIAL SECURITY NO. <u>217-36-215</u>		17. INFORMANT <u>Paul Mitchell, Delmar, Ind.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm Aorta</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis</u> DUE TO (c) _____ </td> <td> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>years</u> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm Aorta</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>years</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm Aorta</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-17-60</u>					
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>M. P.</u>					
22d. LOCATION (City, town, or county) <u>Delmar, Ind</u>		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Garrel Co - Delmar Ind</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4014

CERTIFICATE OF DEATH

Reg. Dist. No.

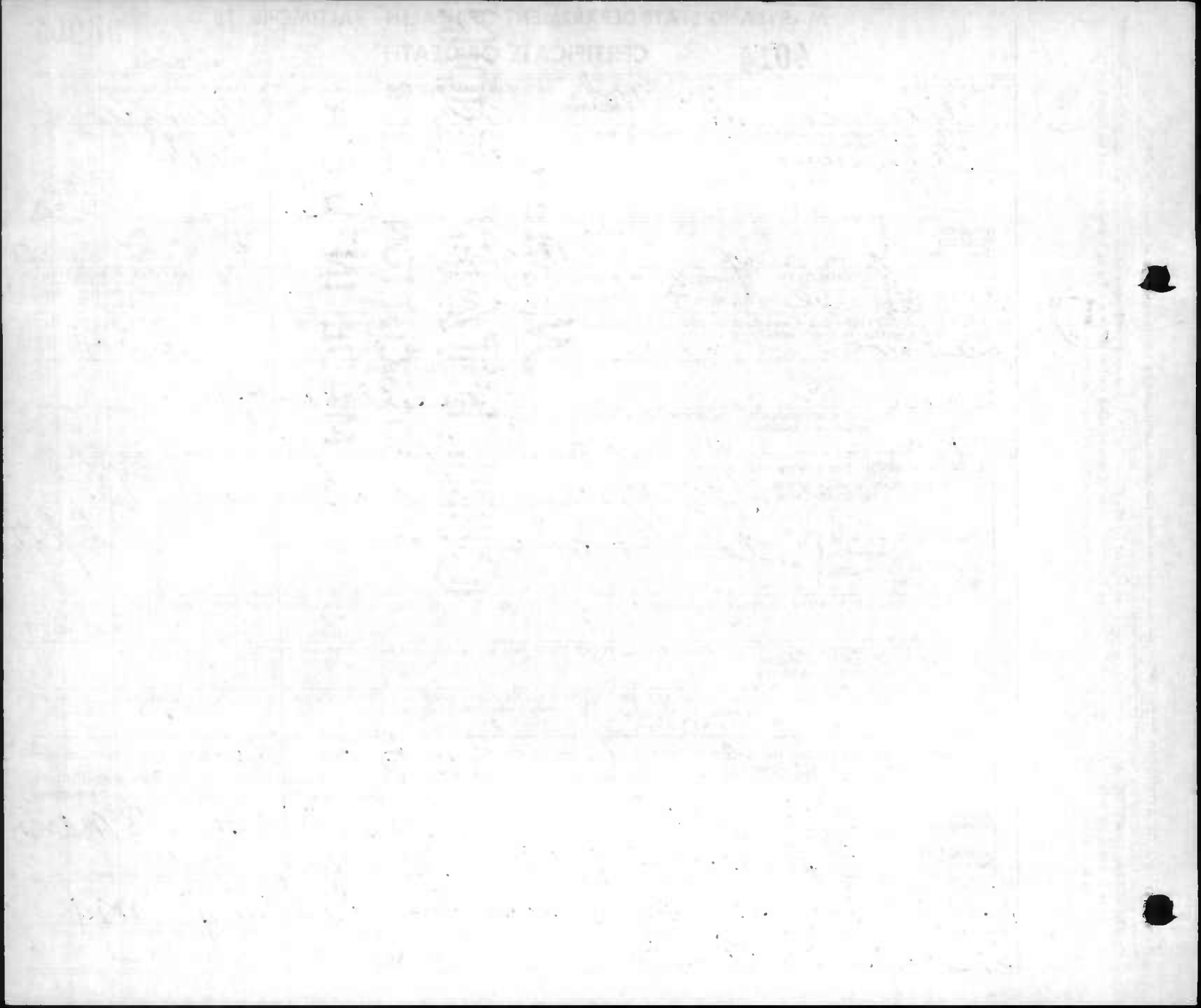
1. PLACE OF DEATH a. COUNTY <u>Chesapeake</u> <u>MD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>md</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chesapeake</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Red are</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jennings</u> Middle <u>Mapp</u> Last <u>Mapp</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-82</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>va</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harold Mapp</u>	
14. MOTHER'S MAIDEN NAME <u>Pericla Mapp. ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>217-10-2029</u>		INFORMANT <u>Pericla Mapp.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 Feb 60</u> to <u>5 March 1960</u> , that I last saw the deceased alive on <u>5 March 1960</u> , and that death occurred at <u>3:21 M</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6534 N. MAIN</u> DATE SIGNED <u>8 March 1960</u> ACTUAL SIGNATURE <u>E. A. Purnell</u> M.D. PHYSICIAN'S NAME (Type) <u>E. A. PURNELL, MD</u> <u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-10-60</u>	<u>Brown Acres Cem</u>	<u>Salisbury MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boake McEwen</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '60</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



4015

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> 19X-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Henry J.</u> Middle <u>Nelson</u> Last <u>Nelson</u>			4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1873</u>		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Samuel J. Nelson</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Bozman</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>NO</u>			17. INFORMANT Address <u>Mrs. Henry J. Nelson</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with Acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Failure</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enteritis with Acute Gastric Dilatation</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>February, 1959</u> , to <u>March 16, 1960</u> , that I last saw the deceased alive on <u>Feb 26, 1960</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u>		DATE SIGNED <u>3/18/60</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Princess Anne, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson, Princess Anne, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. House</u>					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

082

1

2

1

VS A15 (4)
15M 9/58

0.45

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4016
CERTIFICATE OF DEATH

03963

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>31 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown (R.F.D. #1) 17X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Rebecca</u> Last <u>Nickerson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>19 60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-21-85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Frank Tower</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Touck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Deer's Head Records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis due to arteriosclerosis</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-22</u> <u>19 60</u> to <u>3-24</u> <u>19 60</u> that (I) (we) last saw the deceased alive on <u>3-24</u> <u>1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>V. Juerman</u>				22b. DATE <u>3-24-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				22d. ADDRESS <u>Deer's Head State Hospital</u> <u>Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rich Neck Hall Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>nr. Church Hill Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benneth Wally</u>				ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

STATE OF TEXAS

1913



4017

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>106 Jenkins Lane</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 Jenkins Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Parsons</u> Last <u>Parsons</u>				4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-10</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>5</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Emma Parsons</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3-25-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gloss Hill Cem</u>	22d. LOCATION (City, town, or county) <u>Personsburg</u>		(State) <u>md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. Celest</u>			ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 28 60</u>	24b. REGISTRAR'S SIGNATURE <u>Carroll J. ...</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MD-04 EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03965

Reg. Dist. No.

4018

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>D.O.A</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Quantico Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Pollitt</u> Last <u></u>				4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JULY 4, 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEVIN POLLITT</u>				14. MOTHER'S MAIDEN NAME <u>ANNE MARIA RALPH</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>MRS. B. FRANK PARSONS - Salisbury, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car involved in a collision on Route # 50</u>						
20c. TIME OF INJURY Month, Day, Year <u>9:45 A.M. 3-1-60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route #50</u>		20f. (City or town) (County) (State) <u>Wicomico Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-4-60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-5-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Salisbury, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX OF DECEASED _____	
3. AGE OF DECEASED _____		4. DATE OF DEATH _____	
5. PLACE OF DEATH _____		6. TIME OF DEATH _____	
7. OCCUPATION OF DECEASED _____		8. CAUSE OF DEATH _____	
9. MANNER OF DEATH _____		10. SIGNATURE OF MEDICAL EXAMINER _____	
11. SIGNATURE OF WITNESS _____		12. SIGNATURE OF DECEASED _____	
13. SIGNATURE OF DECEASED _____		14. SIGNATURE OF DECEASED _____	
15. SIGNATURE OF DECEASED _____		16. SIGNATURE OF DECEASED _____	
17. SIGNATURE OF DECEASED _____		18. SIGNATURE OF DECEASED _____	
19. SIGNATURE OF DECEASED _____		20. SIGNATURE OF DECEASED _____	
21. SIGNATURE OF DECEASED _____		22. SIGNATURE OF DECEASED _____	
23. SIGNATURE OF DECEASED _____		24. SIGNATURE OF DECEASED _____	
25. SIGNATURE OF DECEASED _____		26. SIGNATURE OF DECEASED _____	
27. SIGNATURE OF DECEASED _____		28. SIGNATURE OF DECEASED _____	
29. SIGNATURE OF DECEASED _____		30. SIGNATURE OF DECEASED _____	
31. SIGNATURE OF DECEASED _____		32. SIGNATURE OF DECEASED _____	
33. SIGNATURE OF DECEASED _____		34. SIGNATURE OF DECEASED _____	
35. SIGNATURE OF DECEASED _____		36. SIGNATURE OF DECEASED _____	
37. SIGNATURE OF DECEASED _____		38. SIGNATURE OF DECEASED _____	
39. SIGNATURE OF DECEASED _____		40. SIGNATURE OF DECEASED _____	
41. SIGNATURE OF DECEASED _____		42. SIGNATURE OF DECEASED _____	
43. SIGNATURE OF DECEASED _____		44. SIGNATURE OF DECEASED _____	
45. SIGNATURE OF DECEASED _____		46. SIGNATURE OF DECEASED _____	
47. SIGNATURE OF DECEASED _____		48. SIGNATURE OF DECEASED _____	
49. SIGNATURE OF DECEASED _____		50. SIGNATURE OF DECEASED _____	
51. SIGNATURE OF DECEASED _____		52. SIGNATURE OF DECEASED _____	
53. SIGNATURE OF DECEASED _____		54. SIGNATURE OF DECEASED _____	
55. SIGNATURE OF DECEASED _____		56. SIGNATURE OF DECEASED _____	
57. SIGNATURE OF DECEASED _____		58. SIGNATURE OF DECEASED _____	
59. SIGNATURE OF DECEASED _____		60. SIGNATURE OF DECEASED _____	
61. SIGNATURE OF DECEASED _____		62. SIGNATURE OF DECEASED _____	
63. SIGNATURE OF DECEASED _____		64. SIGNATURE OF DECEASED _____	
65. SIGNATURE OF DECEASED _____		66. SIGNATURE OF DECEASED _____	
67. SIGNATURE OF DECEASED _____		68. SIGNATURE OF DECEASED _____	
69. SIGNATURE OF DECEASED _____		70. SIGNATURE OF DECEASED _____	
71. SIGNATURE OF DECEASED _____		72. SIGNATURE OF DECEASED _____	
73. SIGNATURE OF DECEASED _____		74. SIGNATURE OF DECEASED _____	
75. SIGNATURE OF DECEASED _____		76. SIGNATURE OF DECEASED _____	
77. SIGNATURE OF DECEASED _____		78. SIGNATURE OF DECEASED _____	
79. SIGNATURE OF DECEASED _____		80. SIGNATURE OF DECEASED _____	
81. SIGNATURE OF DECEASED _____		82. SIGNATURE OF DECEASED _____	
83. SIGNATURE OF DECEASED _____		84. SIGNATURE OF DECEASED _____	
85. SIGNATURE OF DECEASED _____		86. SIGNATURE OF DECEASED _____	
87. SIGNATURE OF DECEASED _____		88. SIGNATURE OF DECEASED _____	
89. SIGNATURE OF DECEASED _____		90. SIGNATURE OF DECEASED _____	
91. SIGNATURE OF DECEASED _____		92. SIGNATURE OF DECEASED _____	
93. SIGNATURE OF DECEASED _____		94. SIGNATURE OF DECEASED _____	
95. SIGNATURE OF DECEASED _____		96. SIGNATURE OF DECEASED _____	
97. SIGNATURE OF DECEASED _____		98. SIGNATURE OF DECEASED _____	
99. SIGNATURE OF DECEASED _____		100. SIGNATURE OF DECEASED _____	

4040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03966

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Tyaskin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 1</u>				d. STREET ADDRESS <u>Route # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bruce Richardson</u>				4. DATE OF DEATH Month Day Year <u>3-10-1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/59</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lennie Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Helen Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Helen Jones, Tyaskin, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-11-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Head of Creek Cem. Quantico, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Messink, Bldg. We, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

MEDICAL CERTIFICATION

2

2

2082286XU5

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
Page 4
24 hours after death.
The low requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4019

CERTIFICATE OF DEATH

Reg. Dist. No.

03967

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Wicomico</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>12th Salisbury</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>New Sen Hosp.</i>		d. STREET ADDRESS <i>219 Broad St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Satchell</i> Last <i>Satchell</i>		4. DATE OF DEATH Month <i>3</i> Day <i>1</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>cel</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-19-84</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. UNDER 1 YEAR Months <i>6</i> Days <i>1</i> Hours <i>1</i> Min.	11. UNDER 24 HRS. Months <i>6</i> Days <i>1</i> Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>Indefinite</i>	
13. FATHER'S NAME <i>Jackson Satchell</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Burton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs Rhinia Parsons</i>		Address <i>Salisbury Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Sclerosis</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>Indefinite</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1, 1959</i> to <i>Mar 1, 1960</i> that I last saw the deceased alive on <i>12/30/59</i> , 19 <i>60</i> , and that death occurred at <i>11:30 AM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. H. Kurnell</i> M.D.		DATE SIGNED <i>3 Mar 60</i>	
PHYSICIAN'S NAME (Type) <i>E. H. Kurnell</i>		ADDRESS (Street, city or town, state) <i>Salisbury Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-5-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brown Acres</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Brooke M. West</i>		ADDRESS <i>Salisbury Md.</i>	
24a. REGISTRY REGISTRAR <i>MAR 1 1960</i>		DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>		DATE	

STATE OF NEW YORK
IN SENATE
January 10, 1901
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1901.

RECEIVED
JAN 11 1901
STATE OF NEW YORK
OFFICE OF THE COMMISSIONER OF THE LAND OFFICE
ALBANY

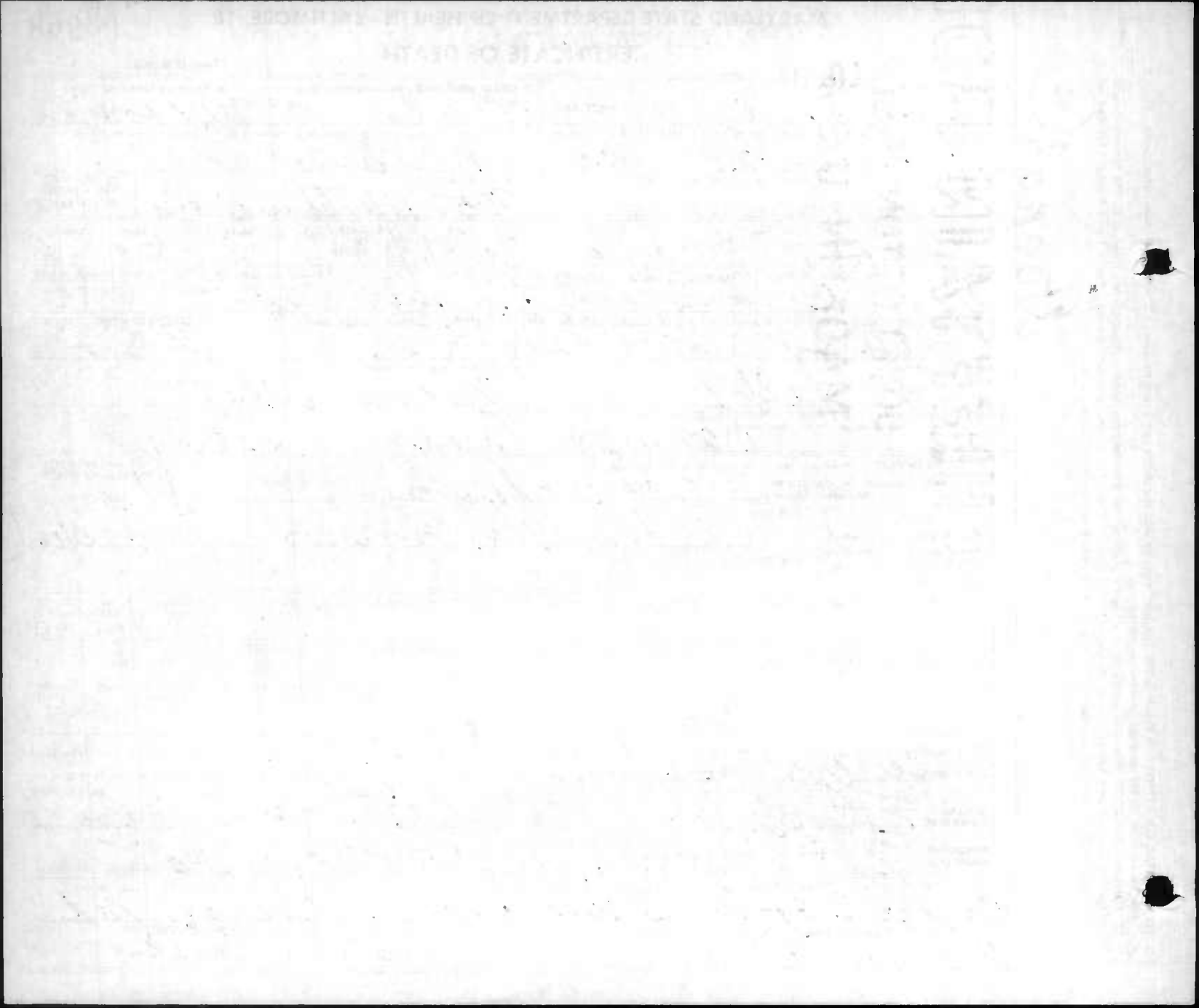
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>715 West Over Drive, Private Home</u>		d. STREET ADDRESS <u>705 Westover Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>HARVEY</u> First <u>COOK</u> Middle <u>SELBY</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Del</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm Selby</u>	
14. MOTHER'S MAIDEN NAME <u>Mary West</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>220-10-9886</u>		17. INFORMANT <u>Theodore Selby</u> Address <u>Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebroscloisis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Indefinite</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19 Mar 1959</u> to <u>30 Mar 1960</u> , that I lost saw the deceased alive on <u>20 Mar 1960</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. A. Furnell</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, md</u> DATE SIGNED <u>23 Mar 60</u>	
PHYSICIAN'S NAME (Type) <u>E. A. Furnell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-24-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE MAR 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>CINDY</u> Last <u>Shockley</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>May 18, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>84</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
15. FATHER'S NAME <u>--- (Unk) --- Hearn</u>		16. MOTHER'S MAIDEN NAME <u>--- (Unk) --- Foskey</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>MR. Norman P. Shockley (Son) R.D.# Parsonsbury, Maryland</u>	
19. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Lower Lobe pneumonia with 491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>diffuse Right broncho pneumonia</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 March 1960</u> , to <u>death</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>22 March</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert F. Adkins</u> M.D.		DATE SIGNED <u>23 March 1960</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Robert Adkins</u>		<u>Fruitland, Maryland</u> <u>23 Mar. 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar. 26, 1960</u>	<u>Parsonsbury Cemetery</u>	<u>Parsonsbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>		<u>MAR 24 '60</u>	<u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

03970

4022

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS Parsonsburg			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last SICKLES				4. DATE OF DEATH Month 3 Day 5 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Sickles				14. MOTHER'S MAIDEN NAME Euphemia Henderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 143-10-3614		17. INFORMANT Mrs. Helen Sickles- Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myo cardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar 3/5 , 19 60 , to 3/5 , 19 60 , that I last saw the deceased alive on 3/5 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 3-7-1960							
ACTUAL SIGNATURE Earl Beardsley M.D. Salisbury, Maryland				3-7-1960			
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley, Maryland Ave., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-1960		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR MAR 9 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

4023

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury,				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				d. STREET ADDRESS 208 Sheffield Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Lawrence Smith				4. DATE OF DEATH Month Day Year March 17 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1880		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Chief Navy Officer U.S.N.			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William H. Smith				14. MOTHER'S MAIDEN NAME Julia Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or date of service) 1899-1930				16. SOCIAL SECURITY NO. 1299-1930			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-15, 1960 , to 3-17, 1960 that I last saw the deceased alive on 3-17, 1960 , and that death occurred at 5 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilbur R. Ellis Jr. M.D. Salisbury, Md.				DATE SIGNED 3-17-60			
PHYSICIAN'S NAME (Type) Wilbur R. Ellis Jr., M.D., Medical Center, Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar 19-1960		22c. NAME OF CEMETERY OR CREMATORY St. George's	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				24a. REC'D BY REGISTRAR Mar 22 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

03972

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt #2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Louis</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 21, 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Smith</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>217-36-1121</u>		17. INFORMANT Address <u>Mrs. Wm Smith, Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> <u>420.1</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Aortic Insufficiency</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Esophageal Stenosis - Cause Undetermined</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 21, 1956</u> to <u>March 10, 1960</u> , that I last saw the deceased alive on <u>Jan 20, 1960</u> , and that death occurred at <u>3:42 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr.</u>				DATE SIGNED <u>3-11-1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>3-13-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Siloam Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Siloam, MARYLAND</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u>				ADDRESS <u>Salisbury, MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03973

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen Hospital				/d. STREET ADDRESS R.D.# 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BESSIE Middle E. Last SNELLING				4. DATE OF DEATH Month MARCH Day 19th Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1902		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 5 Days 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator-Manhattan Shirt Co. (Employee) Princess Anne, Md.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William J. Stevenson				14. MOTHER'S MAIDEN NAME Mary Anne Trehearn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. James R. Snelling (Husband) R.D.# 2 Eden, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General anesthesia for cholecystectomy							INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				DATE SIGNED March 22 / 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Mar. 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 24 '60	
				24b. REGISTRAR'S SIGNATURE Carlton S. Huns			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03974

4025

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 55 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Lillian Middle Viola Last Spencer				4. DATE OF DEATH Month March Day 22 Year 19 60					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/22/09			
9. AGE (In years lost birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Clarence Dorsey				14. MOTHER'S MAIDEN NAME Ada Brooks					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. 218-20-7817		17. INFORMANT Deer's Head Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 442X DUE TO Arteriolar nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } DUE TO Arteriosclerosis, general								INTERVAL BETWEEN ONSET AND DEATH 2 years ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myxedema								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan. 26 19 60 to March 22 19 60 , that (I) (we) lost saw the deceased alive on March 21 19 60 , and that death occurred at 3:25 A.M. M, from the causes and on the date stated above.									
22a. SIGNATURE V. Juerman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/22/60			
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.				22d. ADDRESS Deer's Head Hospital; Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/60		23c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.		23d. LOCATION (City, town, or county) (State) RFD Worton, Md. (Coleman's)			
24. FUNERAL DIRECTOR'S SIGNATURE Senneth Walby				ADDRESS Chestertown, Md.		25a. REGISTRY SIGNATURE MAR 28 60			
25b. REGISTRY SIGNATURE Curran S. Pines									

CERTIFICATE OF DEATH

1003



Blank lines for text entry, including fields for name, date, and location.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

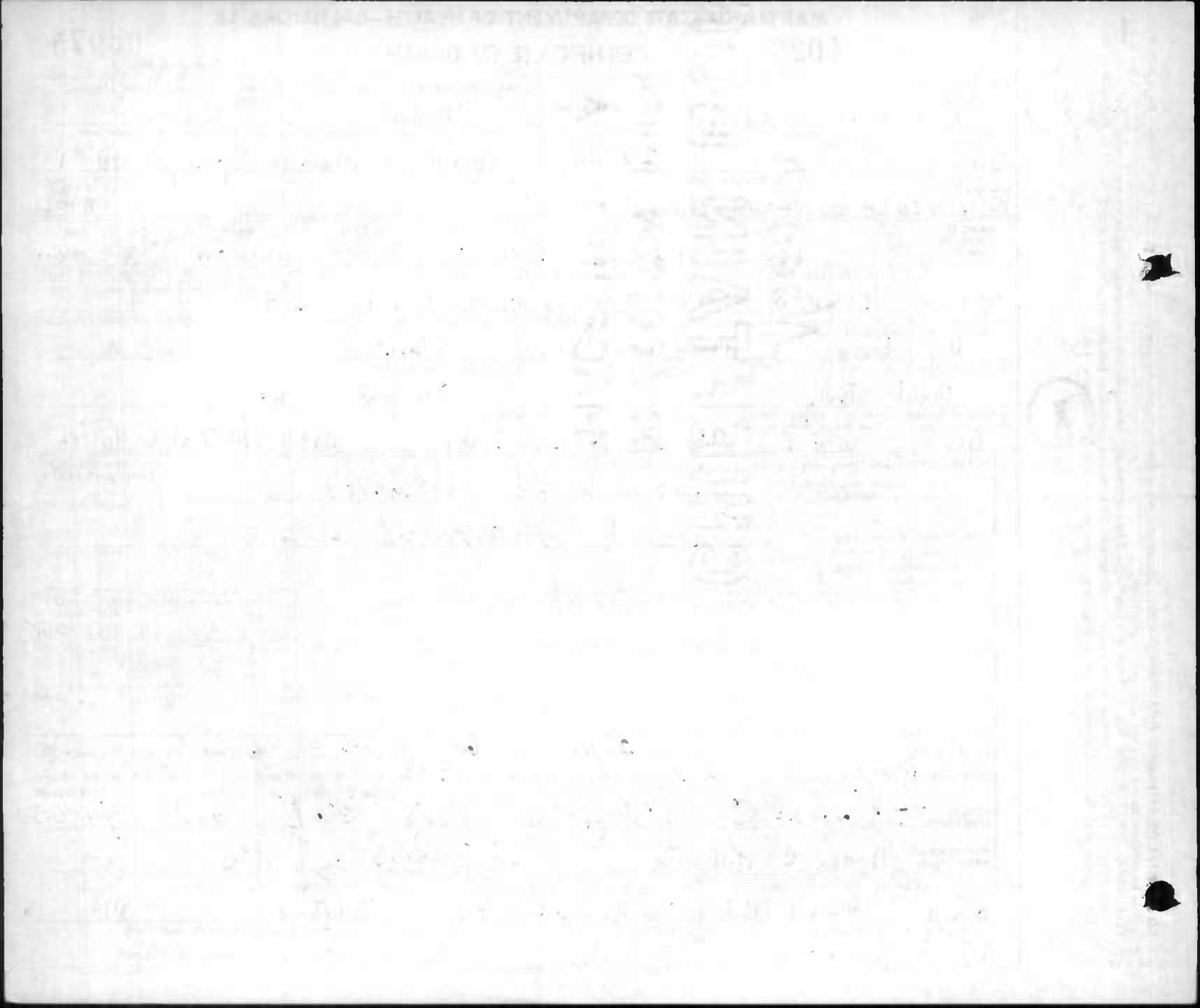
4026

CERTIFICATE OF DEATH

Reg. Dist. No.

03975

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>22 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL - MARDELA SPRINGS RD #1</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEVI</u> Middle <u>HARRISON</u> Last <u>STANLEY</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DECEMBER 3, 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>63</u> Days <u>63</u> Hours <u>63</u> Min.		IF UNDER 24 HRS. Months <u>63</u> Days <u>63</u> Hours <u>63</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Marvil Package Company</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DANIEL STANLEY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET GOSLEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>222-07-0987</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>2-11-</u> 19 <u>60</u> , to <u>March 3</u> 19 <u>60</u> , that I last saw the deceased alive on <u>March 3</u> 19 <u>60</u> , and that death occurred at <u>3:58</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road 3/4/60</u> DATE SIGNED <u>3/4/60</u>			
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>				<u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SAN DOMINGO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Shedden Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton & Son</u>				ADDRESS <u>FEDERALSBURG</u>		24a. REC'D BY REGISTRAR <u>MAR 10 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4027

CERTIFICATE OF DEATH

Reg. Dist. No. 03976

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nikton Wilson Stewart</u>				4. DATE OF DEATH Month Day Year <u>March 22 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 7 1901</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>25-03-7852</u>			
				INFORMANT Address <u>Miss Lillian Stewart Mt. Vernon, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>445X</u> DUE TO <u>Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Essential</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct.</u> 19 <u>54</u> to <u>March 22</u> 19 <u>60</u> that I last saw the deceased alive on <u>March 21</u> 19 <u>60</u> and that death occurred at <u>12:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				DATE SIGNED <u>3/22/60</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Ind.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Vernon Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Prince Anne Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>MAR 28 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1903

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03977

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>504 S. Pinehurst St.</u>			d. STREET ADDRESS <u>504 S. Pinehurst St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Lee</u> Last <u>Truitt</u>			4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>60</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-99</u>		9. AGE (In years last birthday) <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Line Sales Rep.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>Joseph C. Truitt</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Calloway</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Irene Gravenor Truitt, Salisbury.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Earl L. Royer</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-2-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-3-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Firemans Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Sharptown, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W Smith</u>			24. REC'D BY REGISTRAR <u>APR 5 '60</u>		25. REGISTRAR'S SIGNATURE <u>Clifton S. Finner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page from the papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4029

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03978

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 Yr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman Island</u>		<u>20X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>----</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>-----</u> Last <u>Tyler</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1860</u>
9. AGE (In years last birthday) <u>99</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Cummings</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records -- Salisbury, Marland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Senility</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8/16/55</u> 19 <u> </u> to <u>3/13/</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/13/</u> 19 <u>60</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lee L. Lawry</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>Feb. 16, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Tilghman Island, Talbot</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		ADDRESS <u> </u>	
25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 16 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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4030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>9 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X White Haven</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>082 PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>L.</u> Last <u>VALENTINE</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/26/90</u>		9. AGE (In years last birthday) yrs. <u>69</u>	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pz.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Richard Valentine</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.2</u> DUE TO <u>Coronary Heart Failure (c) at Ventricular Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Asthenia</u> (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 17, 1960</u> , to <u>March 25, 1960</u> , that I last saw the deceased alive on <u>3/25/60</u> , 19 <u>60</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Carrie Hearn</u>		M.D. <u>226 N. Division St</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Birchview Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Birchview, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond Messitt, Birchview, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03980

4042

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Delmar Rd)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HIRAM G WATSON		4. DATE OF DEATH Month MARCH Day 7th Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Poultry Grower-Chickens		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Minos Burton Watson		14. MOTHER'S MAIDEN NAME Elizabeth Betts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Annie A. Watson (Wife)		Address R.D.# 3 Delmar Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of prostate gland 177X DUE TO with generalized metastases to bone tissue Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 53 to March 7, 19 60 , that I last saw the deceased alive on March 5, 19 60 , and that death occurred at 12:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. L. V. Sohler M.D.		ADDRESS (Street, city or town, state) Delmar, Maryland	
DATE SIGNED March 8, 1960			
PHYSICIAN'S NAME (Type) Dr. L. V. Sohler			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Mar. 9, 1960	Parsons Cemetery	Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
24a. REC'D BY REGISTRAR MAR 10 '60		24b. REGISTRAR'S SIGNATURE William L. Hanes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

Name of Deceased		Age		Sex		Race		Color	
John Doe		45		Male		White		White	
Place of Birth		Date of Birth		Date of Death		Time of Death		Cause of Death	
New York City		Jan 1, 1857		Jan 15, 1902		10:00 AM		Heart Disease	
Occupation		Marital Status		Education		Religion		Burial Place	
Teacher		Married		High School		Roman Catholic		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Certificate		Name of Hospital		Name of Doctor		Name of Nurse	
Jan 15, 1902		Baltimore, Md.		St. Mary's Hospital		Dr. J. H. Smith		Miss A. B. Jones	

4031

CERTIFICATE OF DEATH

03981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 Wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				1. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George F</u> First Middle Last				4. DATE OF DEATH <u>March 16</u> 19 <u>60</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/6/11/1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Jacob Weisel</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Vowlmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u> INFORMANT Address <u>Lucille Weisel, White Haven, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Degenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>3-16</u> , 19 <u>60</u> , and that death occurred at <u>3:20</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Elder</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>3-16-60</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalve, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Compass, Bivalve, Md.</u> ADDRESS				24a. REC'D. BY REGISTRAR <u>MAR 22 60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
ISM 9/58

